Making Posttraumatic Stress Disorder a Priority: Saving Veterans from Suicide

Daniel Reidenberg*  Natasha Shaikh†

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I. INTRODUCTION

When young Americans volunteer their lives to go and serve in the armed services, they often fail to realize that they are making a commitment that will last for the rest of their lives. Rarely do they consider that it may even shorten their lives. Inadequate treatment for veterans who have post-traumatic stress disorder (PTSD) leads to the symptoms progressing, and for...
some, consequently results in suicide.\textsuperscript{1} Today, “more active duty soldiers commit suicide than are killed in combat,” which reflects negatively on the United States Military.\textsuperscript{2} The lack of proper care and attention awarded to veterans and military personnel is apparent in Specialist Kirkland’s story.\textsuperscript{3} Kirkland, a soldier who had been deployed to Iraq twice, was sent home because the symptoms of PTSD were hindering his ability to live.\textsuperscript{4} When he returned to the barracks, he was publicly ridiculed for having PTSD and assigned to a room by himself.\textsuperscript{5} Forty-eight hours later he was found dead.\textsuperscript{6} While it may have been his hands that physically took his life, “Kirkland did not kill himself. He was killed by the Army” as a result of the inadequate treatment.\textsuperscript{7}

PTSD, which occurs in a high number of veterans, when left untreated, often leads to suicide.\textsuperscript{8} Preventing suicide among veterans with PTSD is directly linked to the legal system, because the law determines whether a veteran can qualify for disability benefits to receive treatment for disabilities incurred during service.\textsuperscript{9} Providing adequate care to veterans is dependent on specific laws set forth by the United States, which enable the Department of Veteran Affairs (VA) and the Department of Defense (DoD) to provide adequate and efficient services to veterans.\textsuperscript{10} Additionally, the actions taken by the United States in decreasing the stigma attached with mental illnesses will help reduce suicide rates among veterans.\textsuperscript{11}

PTSD has been linked to a heightened risk of suicide among veterans, due to untreated symptoms of PTSD, which include: “[D]epression, anxiety, sleep deprivation, substance abuse, and difficulties with anger management.”\textsuperscript{12} Unfortunately, suicide rates in the military are at an all-time high,
and the number of psychiatric illnesses, namely PTSD, are on the rise.\textsuperscript{13} “PTSD is the only [mental] illness [that has] a clear etiologic[al] relationship to military service . . .” and it has been demonstrated that being exposed to war-zone stress can lead to life-lasting impairment.\textsuperscript{14} In 2012, a study revealed that veterans who attempted suicide did not do so because they wanted to harm themselves; rather, they did so because they wanted the pain they were experiencing to end.\textsuperscript{15} Despite the prevalence of PTSD among veterans,\textsuperscript{16} few studies have been conducted and little is known about how to help them. The issue of rendering aid to returning veterans and preventing them from committing suicide has been placed under a spotlight of national scrutiny, which is evidenced by recent actions by President Barack Obama and the members of the Congress.\textsuperscript{17}

As veterans return and are not properly cared for, the reputation of the military as well as individuals’ desires to volunteer for the military will decrease, which is manifested in George Washington’s declaration, “‘[t]he willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the [v]eterans of earlier wars were treated and appreciated by their nation.’”\textsuperscript{18} It is crucial that this topic be addressed with urgency because in the next five years a million soldiers are expected to return from combat,\textsuperscript{19} and in order to prevent suicide, it is integral that equal importance is given to mental wounds as is to physical wounds.\textsuperscript{20} Part two of this article defines PTSD and suicide both generally and in the military.\textsuperscript{21} Then, part three discusses the problem of the increasing rates of suicide amongst veterans with PTSD.\textsuperscript{22} Specifically, after explaining the general issues, the article discusses the legal obstacles that arise among veterans with PTSD.\textsuperscript{23} Part four illustrates the current ef-

\textsuperscript{14} Robert Rosenheck & Alan Fontana, \textit{Changing Patterns of Care for War-Related Post-Traumatic Stress Disorder at Department of Veterans Affairs Medical Centers: The Use of Performance Data to Guide Program Development}, 164 MILITARY MED. 795, 795 (1999).
\textsuperscript{16} See Rosenheck & Fontana, supra note 14, at 795–96.
\textsuperscript{17} See Brauser, supra note 13.
\textsuperscript{18} HARRELL & BERGLASS, CTR. FOR A NEW AM. SEC., supra note 12, at 10.
\textsuperscript{19} Brauser, supra note 13.
\textsuperscript{20} See HARRELL & BERGLASS, CTR. FOR A NEW AM. SEC., supra note 12, at 5–6.
\textsuperscript{21} See infra Part II.
\textsuperscript{22} See infra Part III.
\textsuperscript{23} See infra Part III.B.
forts that are being taken to address the problem.\textsuperscript{24} Next, part five makes suggestions of what should be done to curtail the detrimental effects that PTSD has on veterans to prevent suicide.\textsuperscript{25} Finally, part six concludes that there is an increasing rate of suicide among returning veterans with PTSD and that rectifying the issue of suicide by veterans with PTSD is necessary.\textsuperscript{26}

II. DEFINING PTSD AND SUICIDE

A history of PTSD has been linked to an increased risk of suicide attempts among veterans.\textsuperscript{27} Individuals with PTSD are at a higher risk for suicidal behavior, which has been illustrated by two studies.\textsuperscript{28} In the first study, a community sample showed that a veteran with PTSD was “14.9 times more likely to attempt suicide than [a veteran] without PTSD.”\textsuperscript{29} In the second study, an Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) screened sample demonstrated that a veteran with PTSD is “over four times more likely to endorse suicidal ideation than [a veteran] without PTSD.”\textsuperscript{30} Veterans with PTSD possess an increased desire to engage in self-harm as a means of dealing with their overwhelming internal experiences, often because they have survivor guilt, have taken lives before, and have sustained combat injuries.\textsuperscript{31}

A. PTSD Generally and in the Military

PTSD is a “trauma-related emotional disturbance” that has been a challenge for the mental health community “since its inception in 1980.”\textsuperscript{32} PTSD has been defined as “‘[a]n anxiety disorder resulting from exposure to an...
experience involving direct or indirect threat of serious harm or death.’” 33
The term PTSD “was first introduced [by the American Psychiatric Association] in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III).” 34 Currently, the text revision of the fourth edition (DSM-IV-TR), which was published in 2000, is followed, and is limited to mostly descriptive changes to the DSM-IV. 35 The fifth revision of the Diagnostic and Statistical Manual of Mental Disorders is expected to be released in 2013. 36

Pursuant to title 38, section 4.125 of the Code of Federal Regulations, the VA has adopted the DSM-IV for rating psychiatric conditions. 37 The DSM-IV explicitly lists military combat as a type of traumatic event which gives rise to PTSD. 38 According to the DSM-IV, an individual must satisfy six criteria in order to be diagnosed with PTSD. 39 First, there must have been a stressor, which means that the individual must have been introduced to a traumatic event “that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others,” and the response to that threat must have “involved intense fear, helplessness, or horror.” 40 Once the first factor is satisfied, the second through fourth criteria explain that the symptoms include: Persistent re-experiencing of the traumatic event (Criterion B), “[p]ersistent avoidance of stimuli associated with the trauma and numbing of general responsiveness” (Criterion C), and “[p]ersistent symptoms of increased arousal” (Criterion D). 41 The fifth criterion mandates that the duration of the symptoms experienced must be present for more than one month. 42 The sixth factor assesses functional significance of the individual and further requires a physician to specify whether the PTSD is acute—symptoms last less than three months—or chronic—symptoms last three or more months. 43 The second requirement of persistent reexperiencing consists of:

34. Foa & Meadows, supra note 32, at 450.
36. Id.
39. See id. at 467–68.
40. Id. at 467.
41. Id. at 468.
42. Id.
43. DSM-IV-TR, supra note 38, at 468.
(1) [R]ecurrent and intrusive distressing recollections of the event, . . . (2) recurrent distressing dreams of the event, . . . (3) acting or feeling as if the traumatic event were recurring, . . . (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event, [or] (5) physiological reactivity [up]on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.44

The avoidant/numbing factor includes:

(1) [E]fforts to avoid thoughts, feelings, or conversations associated with the trauma; (2) efforts to avoid activities, places, or people that arouse recollections of the trauma; (3) inability to recall an important aspect of the trauma; (4) markedly diminished interest or participation in significant activities; (5) feeling of detachment or estrangement from others; (6) restricted range of affect; [and] (7) [a] sense of . . . foreshortened future.45

The element of hyper-arousal involves “(1) difficulty falling or staying asleep, (2) irritability or outbursts of anger, (3) difficulty concentrating, (4) hypervigilance, [and an] (5) exaggerated startle response.”46

PTSD is caused by stress factors and it has been found that when the stress is caused by human design, PTSD “is more severe and lasts longer.”47 Individuals experiencing PTSD exhibit self-destructive and dangerous behavior, including “[s]ubstance use, [s]uicidal attempts, [r]isky sexual behavior, [r]eckless driving, [and] [s]elf-injury.”48 Treatment for PTSD includes hypnotherapy; psychodynamic treatments; cognitive-behavioral treatments such as exposure procedures, systematic desensitization, prolonged imaginal and in vivo exposure; anxiety management programs; and combined treatment programs.49

PTSD has been utilized in courts as a basis for the insanity defense, as well as a mitigating factor at sentencing for veterans who were involved in combat.50 Approximately “30% of combat veterans experience PTSD.”51

44. Id. (stating that the traumatic event is reexperienced, persistently, in at least one of the ways mentioned).
45. Id.
46. Id.
47. Bulman, supra note 27, at slide 15.
48. Id. at slide 16.
which has been associated with being deployed multiple times, and a lack of
time available to spend at home to lead a normal, healthy life, inevitably re-
sulting in emotional problems and then the commission of suicide.\textsuperscript{52} The
most common reason why army personnel are being hospitalized is due to
psychiatric illnesses such as PTSD.\textsuperscript{53}

While PTSD is often not given as much importance because it is per-
ceived as a mental illness, a recent study showed that individuals experienc-
ing PTSD do exhibit physical alterations in their brain.\textsuperscript{54} In November 2012,
a study indicated that combat veterans with PTSD had a smaller volume in
the amygdala, the primary area of the brain that regulates responses to stress,
fear, and anxiety, which is significant because it indicated that a physical
alteration is associated with PTSD, “regardless of the severity of trauma.”\textsuperscript{55}
The study analyzed magnetic resonance imaging (MRI) scans of “200 com-
bet veterans who served in Iraq and Afghanistan,” half who had PTSD, and
the other half who had not been diagnosed with PTSD.\textsuperscript{56}

\textbf{B. \textit{Suicide Generally and in the Military}}

According to the Centers for Disease Control and Prevention, “[s]uicide
was the tenth leading cause of death [in the United States] in 2010.”\textsuperscript{57} “Suici-
de is the third leading cause of death” for youth between the ages of fifteen
and twenty-four years old,\textsuperscript{58} which is problematic because many of the sol-
diers serving the country fall within this age range.\textsuperscript{59} Challenges at work,
financial and legal troubles, physical or medical illnesses, struggles in social
life, substance abuse, psychological injury, emotional distress, and mental
disorders including depression, schizophrenia, anxiety disorders, and PTSD.

\begin{thebibliography}{99}
\bibitem{51} Bulman, \textit{supra} note 27, at slide 7.
\bibitem{52} Brauser, \textit{supra} note 13.
\bibitem{53} \textit{See id.}
\bibitem{55} \textit{Id.} However, this study fails to indicate whether a smaller amygdala volume is a
result of trauma, or whether the smaller amygdala volume is what makes soldiers more vul-
nerable to developing PTSD. \textit{Id.}
\bibitem{56} \textit{Id.}
\bibitem{57} CDC, \textit{Suicide: Facts at a Glance} (2012), http://www.cdc.gov/Violence Preven-
tion/pdf/Suicide_DataSheet-a.pdf.
\bibitem{58} \textit{Id.}
\bibitem{59} David R. Segal & Mady Wechsler Segal, \textit{America’s Military Population},
\end{thebibliography}
are all correlated with suicide attempts, suicide ideation, and deaths by suicide, and occur among all age groups and demographic variables.

General Lloyd J. Austin stated, "'[s]uicide is the toughest enemy I have faced in my 37 years in the Army. That said, I do believe suicide is preventable,'" representing a belief that if proper precautions are taken, the number of deaths caused by suicide may decrease. Making suicide prevention a priority is necessary because a policy brief indicated that approximately eighteen veterans take their own lives daily, and between the years of 2005 and 2010, at a rate of about one every thirty-six hours.

The Veterans Health Administration (VHA) has been working to ensure access to mental health services and has created programs tailored to prevent suicides. The suicide of the Chief of Naval Operations, Admiral Jeremy Boorda, served as a "wakeup call" for the military, leading to widespread media attention. This began the development of formal suicide prevention programs in the military. Suicide prevention programs in the Army focus on: "Developing life-coping skills, [e]ncouraging help-seeking behaviors, [r]aising awareness and vigilance to suicide prevention, [i]ntegrating suicide prevention programs, [and] [c]onducting suicide surveillance and analysis." In 2007, the VA implemented a suicide prevention program at the order of the Congress. While the problem is identified, it is hard to prevent because it is difficult to predict which individuals are actually thinking about committing suicide due to the low base rate of suicide. Additionally, the low number of comprehensive assessments of suicide mortality among veterans

61. See CDC, supra note 57.
63. See id.
64. Id.
66. DEP’T OF DEF. TASK FORCE ON THE PREVENTION OF SUICIDE BY MEMBERS OF THE ARMED FORCES, supra note 60, at 11.
67. Id.
68. Id. at 16.
69. McCarthy et al., supra note 65, at 1033.
makes it harder to solve the problem.\textsuperscript{71} There has also been no assessment of suicide rates among veterans who are receiving aid from the VHA health system.\textsuperscript{72}

III. THE PROBLEM

A. Generally

During the month of July 2012, “26 active-duty soldiers and 12 reserve soldiers [committed suicide], which is the highest number ever recorded in 1 month.”\textsuperscript{73} The United States Army confirmed an overall rise in the number of suicides, evidenced by 116 active-duty suicides and 71 reservist suicides in just the first seven months of 2012, as compared to 165 active duty and 118 reservist suicides in all of 2011.\textsuperscript{74} One of the greatest challenges that both the mental health community and the VHA healthcare system face is that of veterans with PTSD experiencing suicidal ideation.\textsuperscript{75} Veterans with PTSD who chronically exhibit suicidal ideation consume a disproportionate amount of the limited resources available at hospitals or clinics, which in turn “introduce[s] resource allocation stress into [the] system[], [inevitably leading] to wide-ranging consequences for the entire . . . veteran population” that is seeking treatment.\textsuperscript{76}

There are only two medications, sertraline and paroxetine, approved by the Food and Drug Administration for treating PTSD.\textsuperscript{77} It has been indicated that even the two medications are only effective in a limited capacity.\textsuperscript{78} Often times, in addition to the medicine, the individual seeking recovery might also need psychotherapy, which makes it even harder for an individual to overcome the hurdle.\textsuperscript{79} As a result, many veterans do not attend therapy regularly, and between 20% and 50% of soldiers walk away from PTSD treatment before it is completed.\textsuperscript{80} This has led scientists to look for other medications such as D-cycloserine and ketamine, as well as other promising ther-

\begin{itemize}
\item \textsuperscript{71} McCarthy et al., supra note 65, at 1033.
\item \textsuperscript{72} Id.
\item \textsuperscript{73} Brauser, supra note 13.
\item \textsuperscript{74} Id.
\item \textsuperscript{75} Nye et al., supra note 70, at 1144.
\item \textsuperscript{76} Id.
\item \textsuperscript{77} Michael Dieperink et al., Comparison of Treatment for Post-Traumatic Stress Disorder Among Three Department of Veterans Affairs Medical Centers, 170 MILITARY MED. 305, 305 (2005).
\item \textsuperscript{78} Id.
\item \textsuperscript{79} See Brauser, supra note 13.
\item \textsuperscript{80} Id.
\end{itemize}
apies such as "‘eye movement desensitization, hypnosis, and other talking therapies.’”81

Instead of praising veterans with PTSD for living through traumatic experiences that were experienced during combat, society, including military personnel, looks down upon individuals with PTSD, perceiving them as weak and pitying them.82 The stigma associated with having a mental disorder is the greatest challenge preventing soldiers from seeking help.83 Combating the stigma will be close to impossible because many people do not regard PTSD as a real injury.84 A study conducted in 2008 revealed that the reported rates of PTSD and suicidal thoughts were “two to four times higher” in anonymous surveys as compared to those in post-deployment health assessment (PDHA) surveys.85 Returning soldiers fabricate their answers attempting to conceal any PTSD related symptoms since their unit leaders advise them to.86 Soldiers have been told by their unit leaders, “‘[i]f you answer yes to any of those questions, you are not going home to your family tomorrow,’” resulting in soldiers falsifying responses.87 As an effort to remedy this problem and encourage honesty, the 2010 National Defense Authorization Act (NDAA) necessitates that “PDHA evaluations [be conducted] individually and face-to-face” by “trained medical or behavioral . . . professionals.”88

Additionally, a major problem is the lack of healthcare providers to help veterans who are seeking treatment for PTSD.89 The national shortage of mental health and behavioral healthcare providers has been linked to an increase in suicide rates.90 Even when military hospital commanders have the authority to hire healthcare personnel on an as-needed basis, they cannot do so due to a national shortage of care providers.91 It was found that where the healthcare professionals increased to the number recommended in the Veterans Health Administration Handbook, suicide rates decreased by 3.6 deaths per one hundred thousand.92

81. Id.
82. See Harrell & Berglass, Ctr. for a New Am. Sec., supra note 12, at 5.
83. Id. “[Forty-three] percent of soldiers . . . who took their own lives in 2010 did not seek help from military treatment facilities in the month before their deaths.” Id.
84. Id. at 5–6.
85. Id. at 5.
86. See Harrell & Berglass, Ctr. for a New Am. Sec., supra note 12, at 5.
87. Id.
88. Id.
89. Id. at 6.
90. Id.
92. Id.
Another factor that adds to the problem of veterans not getting adequate treatment is the time delay between the onset of PTSD and the treatment for it.93 Approximately one million veterans are currently waiting on claims for disability from the VA, a number which is only expected to rise in the next several months by 1.2 million.94 It takes the VA, on average, just over eight months to respond to a disability claim, and in the case that a veteran desires to appeal a denied claim, it takes an average of three and a half years.95 The time delay poses a problem because if a veteran with PTSD commits suicide while he or she is not receiving treatment, it is impossible to say that the death could not have been prevented.96

B. Obstacles Presented by the Legal System

The four main legal issues addressed in this article associated with PTSD and suicide among veterans are: (1) The United States judicial system’s ability to take action on the VA’s treatment of veterans;97 (2) the law regarding veterans’ ability to establish a service connection;98 (3) untreated PTSD causing veteran dismissal without disability benefits;99 and (4) laws regarding certain personnel from inquiring when a soldier or veteran owns a personal firearm.100

1. Limited Authority of Federal Courts over the VA

The VA adjudicates the majority of the claims involving veterans because the United States federal courts have limited authority to render decisions over an agency.101 While the Court of Appeals for Veteran Claims has final jurisdiction to review the decisions of the VA, pursuant to section 706(1) of the Administrative Procedure Act, federal courts can only command an agency to act if the agency failed to act in a way it was required to

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94. Id.
95. Ruben Rosario, We’re Quick to Send Them off to War, but Slow to Help, TWIN CITIES.COM (Sept. 22, 2012, 10:27 PM), http://www.twincities.com/localnews/ci_21603734/ ruben-rosario-were-quick-sand-them-off-war.
96. See Levinson, supra note 93; Rosario, supra note 95.
97. See discussion infra Part III.B.1.
98. See discussion infra Part III.B.2.
99. See discussion infra Part III.B.3.
100. See discussion infra Part III.B.4.
do so. The Veterans’ Judicial Review Act of 1988 (VJRA) dictates which federal courts do and do not have jurisdiction in cases involving veteran benefits. The VJRA confers exclusive jurisdiction upon veteran courts to review “all questions involving benefits under laws administered by the VA . . . including factual, legal, and constitutional questions.” By codifying section 511, Congress intended to permanently “broaden the scope of section 211” and limit outside court intervention in the VA decisionmaking process. As a result, federal courts are disqualified from hearing cases regarding veterans’ benefits. For instance, because sections 1705 and 1710 of the United States Code delegate the “[m]anagement of health care [consisting of the] patient enrollment system” and “[e]ligibility for hospital, nursing home, and domiciliary care” to the Secretary of the VA, federal courts lack jurisdiction to judge the agency’s exercise of judgment. This means that federal courts have no say in, or control over, whether the VA is providing timely or effective mental healthcare to veterans. This is extremely problematic because if the VA does not provide timely care, or if it renders ineffective treatment, the federal courts lack the authority to improve the procedure or guidelines utilized by the VA.

2. Service Connections

The VA has a compensation system for veterans with PTSD, allowing veterans to file claims in order to receive disability compensation benefits. Even though the VA was not created until 1930, the custom of providing

103. See Veterans for Common Sense v. Shinseki, 678 F.3d 1013, 1021–22 (9th Cir. 2012) (en banc), cert. denied, 133 S. Ct. 840 (2013). For a detailed explanation of the history of judicial review, and the VJRA, see id. at 1020–23.
104. Id. at 1021 (quoting H.R. REP. NO. 100-963, pt. 1, at 5 (1988)).
106. Shinseki, 678 F.3d at 1022 (quotations omitted); see also H.R. REP. NO. 100-963, pt. 1, at 27. Title 38 of the United States Code Annotated section 511 is subject to four exceptions, one of which allows “[t]he Veterans Court and . . . Federal Circuit [to] review the Secretary’s decisions regarding veterans’ benefits.” Shinseki, 678 F.3d at 1022.
107. Id. at 1022–23.
110. See id.
disability benefits for individuals who served for the United States has been
evident since the Revolutionary War.\footnote{Katherine Dubyak, \textit{Close, but No Cigar: Recent Changes to the Stressor Verification Process for Veterans with Post-Traumatic Stress Disorder and Why the System Remains In-sufficient}, 21 FED. CIR. B.J. 655, 665 (2012).} A veteran looking to receive a certain amount of disability benefits due to an injury caused by a service incurred condition must show that the injury caused by the condition was related to service to the country.\footnote{Doan & Morton, \textit{supra} note 111, at 250.} A “[s]ervice connection connotes . . . that the facts . . . establish that a particular injury or disease resulting in disability was incurred coincident with service in the [a]rmed [f]orces, or if preexisting such service, was aggravated therein.”\footnote{38 C.F.R. § 3.303(a) (2012).} The United States Code mandates that when adjudicating a claim for service connection for PTSD, “the places, types, and circumstances of” service are considered by examining service records, the official history of any organization in which the veteran served, military records, as well as any other pertinent evidence.\footnote{38 U.S.C. § 1154(a)(1) (2006).}

In order to receive a service connection for PTSD, the claimant must show that a claim is well grounded\footnote{See id. § 5107(a).} through: (1) Medical evidence establishing a clear diagnosis of the condition; (2) “credible supporting evidence that the claimed in-service stressor [actually] occurred;” and (3) “a link, established by medical evidence, between current symptoms and an in-service stressor.”\footnote{38 C.F.R. § 3.304(f). The second requirement has commonly been known as the “documentation requirement.” Dubyak, \textit{supra} note 112, at 656.}

Pursuant to an amendment by President Obama in July 2010, when there is no evidence to corroborate that an alleged injury occurred during combat, the Secretary of Veteran Affairs may accept satisfactory lay evidence as long as it is consistent with the conditions of the service.\footnote{38 C.F.R. § 3.304(f)(1)–(4); Dubyak, \textit{supra} note 112, at 656.} Before the amendment in 2010, a soldier serving as a physician for wounded soldiers would not be able to receive disability benefits even if he witnessed his fellow soldiers in an explosion, and as a result, during the explosion, utilized a firearm to protect himself.\footnote{Dubyak, \textit{supra} note 112, at 655–56.} Because the soldier was acting as a physician, it would be close to impossible for the soldier to prove that the in-service stressor actually occurred.\footnote{See id. at 655.} However, as a result of the 2010 amendment, the sole lay testimony of a veteran may be sufficient to establish the existence of an in-service stressor where evidence indicates that PTSD was diag-
nosed during service in the armed forces and that the claimed stressor was associated to the service as long as there is no clear and convincing evidence to the contrary.\footnote{121} The lay testimony may also be sufficient to show the existence of an in-service stressor where it is shown that the veteran was involved with combat and that the claimed stressor was associated with the combat.\footnote{122}

However, it has been held that the mere presence in a combat zone does not constitute a valid stressor to support a PTSD diagnosis; instead, a showing of an event “such as experiencing an immediate threat to one’s life or [observing] another person being . . . killed” is necessary.\footnote{123} This is evidenced in \textit{Gray v. West},\footnote{124} where a veteran, with the military occupational specialty of general warehouseman, was diagnosed with PTSD yet denied entitlement to service connection because he was not able “‘to verify [the] alleged stressors.’”\footnote{125} The court held that it was not enough that the medical diagnosis stated, “‘this man had stressors when he went out on patrol and faced death for the first time,’” and that corroboration of the stressor by “specific dates, places, or names of people killed” was necessary in order to establish a sufficient service connection.\footnote{126} However, a court held that pain or suffering is relevant for a showing of a disability for which service connection can be granted as it is considered in assessing the extent of a condition.\footnote{127} Additionally, there is a presumption of soundness stating that a veteran is presumed to be in “sound condition when examined” for obtaining benefits with the exception of the conditions noted during initial examination.\footnote{128}

Moreover, a service connection can be granted if it is shown that symptoms of a condition were chronic or continuous.\footnote{129} Showing that the symptoms qualify under “service connection” requires the veteran to be diagnosed with the condition during service and at the time of the claim for the service connection.\footnote{130}

While the law regarding service connection was recently amended in 2010, the language of the law is narrowly worded, making it difficult for

\begin{footnotes}
\footnote{121} 38 C.F.R. § 3.304(f)(1); Dubyak, supra note 112, at 656.
\footnote{122} 38 C.F.R. § 3.304(f)(2); Dubyak, supra note 112, at 656.
\footnote{125} Id. at *1.
\footnote{126} Id.
\footnote{127} Sanchez-Benitez v. Principi, 259 F.3d 1356, 1361 (Fed. Cir. 2001).
\footnote{128} 38 C.F.R. § 3.304(b) (2012).
\footnote{129} Id. § 3.303(b).
\footnote{130} Id.
\end{footnotes}
many veterans to obtain disability benefits. With regard to establishing service connection, the requirement of “credible supporting evidence that the claimed in-service stressor actually occurred” should be eliminated, and, instead, lay testimony coupled with confirmations by two or more mental health experts should be sufficient for establishing an in-service stressor. Although this would increase the cost for mental healthcare professionals, a change in this direction would be ultimately beneficial by evading both the pecuniary and societal costs of PTSD left untreated. Making it easier for returning veterans with PTSD to establish service connection is a necessary step to reduce suicide rates because establishing service connection will result in access to treatment for PTSD.

3. The Plight of a Military Defendant Who Is Not Declared Incompetent

Another major legal obstacle that stands in the way of a veteran with PTSD is if the veteran received an Other Than Honorable (OTH) discharge. Pursuant to Title 38 of the United States Code section 1131, the United States will compensate a veteran who incurred a disability during duty, so long as the veteran was “discharged or released under conditions other than dishonorable;” however, if a veteran incurred the disability due to the “veteran’s own willful misconduct or [by substance] abuse,” no compensation will be made. The adjudication regulations followed by the VA are detailed in the Code of Federal Regulations section 3.12, titled “[c]haracter of discharge.” Veterans who receive OTH discharges are generally not eligible to receive disability benefits from the VA, “unless it is found that the person was insane at the time of committing the offense causing such discharge.”

In cases where the defense counsel suspects that the defendant is suffering from PTSD, a sanity board is requested. When the sanity board does not find the defendant insane at the time of the offense, the defendant is faced with an option. The defendant can request a discharge instead of court-martial, which will likely result in an OTH discharge, barring qualifi-
cation for disability benefits. The only exception listed in the Veteran’s Benefit Code (VBC) that permits treatment for veterans with an OTH discharge is when the veteran is declared incompetent. A veteran will hardly ever fall under the exception because the whole reason the defendant was even faced with the option to receive an OTH discharge was because the sanity board did not declare the defendant incompetent in the first place.

Unfortunately, the language of the VBC forces military defendants to face this *Catch-22*: A veteran who is not declared incompetent can opt for an OTH discharge instead of a court-martial, barring disability benefits; but if a veteran has an OTH discharge, he or she can only obtain benefits if declared incompetent. If veterans do not get disability benefits, PTSD symptoms often go untreated, which also often ultimately results in an increase in suicides.

This poses a problem because in the last five years, more than twenty thousand soldiers left the Army with OTH discharges, restricting their access to healthcare and disability benefits. Where a veteran produced medical records detailing PTSD among other injuries, the VA did not qualify him for healthcare because he left the military with an OTH discharge. Unfortunately, so many soldiers are forced to leave the military with OTH discharges because their PTSD is not adequately treated; and when PTSD is left untreated, it leads to the soldiers misbehaving, ultimately and inevitably resulting in an OTH discharge. This is evidenced by a survey conducted in 2010, which indicated that soldiers who served in combat zones and were suffering from PTSD “were more than [eleven] times [as] likely to receive a misconduct discharge” than soldiers without PTSD.

The VBC should be amended to include a provision allowing benefits for disability for veterans regardless of the fact that they have an OTH discharge if the disability is service-connected. Additionally, the standards utilized by the sanity board should be broader, including a full evaluation as

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140. Id. at 54.
141. Id.
142. See id.
145. See id.
146. Id.
147. See id.
148. Id.
149. See Baehr-Jones, *supra* note 137, at 60.
well as treatment options for the judge to consider when sentencing.\footnote{150}{Id. at 63.} Moreover, the VBC should also be amended to explicitly include PTSD within the insanity exception as a basis for being declared incompetent.\footnote{151}{See id. at 60.}

4. Laws Preventing Inquiry of the Possession of Firearms

On January 2, 2013, the United States Congress passed the National Defense Authorization Act (NDAA) for Fiscal Year 2013, amending section 1062(c) of the NDAA for Fiscal Year 2011.\footnote{152}{National Defense Authorization Act for Fiscal Year 2013, Pub. L. No. 112-239, sec. 1057, § 1057, § 1057, 126 Stat. 1938, 1938; see also Ike Skelton National Defense Authorization Act for Fiscal Year 2011, Pub. L. No. 111-383, sec. 1062, § 1062(c), 124 Stat. 4363, 4363.} Before this amendment, it was extremely difficult for military personnel to take preventative measures in terms of high-risk individuals that might possess firearms.\footnote{153}{Compare § 1057, 126 Stat. at 1938, with § 1062, 124 Stat. at 4363.} The legal restrictions set forth in the NDAA for Fiscal Year 2011 forbade anyone in the DoD from collecting any information regarding the legal possession of any firearms.\footnote{154}{Harrell & Berglass, CTR. FOR A NEW AM. SEC., supra note 12, at 6.} The only exceptions permitted were 1) records of the use or possession of firearms “by a member of the Armed Forces or civilian employee of the [DoD]” engaged in official DoD duties or wearing an Armed Forces uniform; or 2) records of an alleged violation, including whether a member of the Armed Forces poses a threat to others.\footnote{155}{Harrell & Berglass, CTR. FOR A NEW AM. SEC., supra note 12, at 6–7.} Military leaders were permitted to discuss personal firearms with soldiers who appeared to have the potential to hurt themselves.\footnote{156}{Harrell & Berglass, CTR. FOR A NEW AM. SEC., supra note 12, at 6–7; see also § 1062, 124 Stat. at 4363.} However, the amendment in the NDAA for fiscal year 2013 authorize[s] a health professional that is a member of the Armed Forces or a civilian employee of the [DoD] or a commanding officer to inquire if a member of the Armed Forces plans to acquire, or already possesses or owns, a privately-owned firearm, ammunition, or other weapon, if such health professional or such com-
manding officer has reasonable grounds to believe such member is at risk for suicide or causing harm to others.\textsuperscript{158}

Inhibiting access to weapons has been indicated to serve as a successful means to prevent suicide;\textsuperscript{159} however, the 2013 provision only allows inquiry regarding whether the veteran owns or plans on purchasing a firearm where the healthcare professional has reasonable grounds to believe that the individual is suicidal.\textsuperscript{160} The 2013 provision still poses problems because: (1) healthcare professionals often do not know that an individual is suicidal; (2) even where a healthcare professional has a hunch that an individual is suicidal, it might be hard for a healthcare professional to prove that hunch based on reasonable grounds; and (3) the potentially suicidal veteran could commit suicide in the time it takes a healthcare professional to properly follow the procedural guidelines to prove reasonable grounds. To fully combat the problem of veterans committing suicide by privately-owned firearms, all military personnel and veterans should be required to report to the DoD and VA whether personal firearms are owned and whether they plan on purchasing any firearms. Implementing such a policy would allow healthcare professionals to monitor veterans with PTSD who own or plan on owning a firearm to be monitored more closely.

IV. CURRENT EFFORTS TO ADDRESS SUICIDE AMONG VETERANS WITH PTSD

A. Government Action to Reduce Suicide Among Veterans Resulting from PTSD

1. Executive Order

On August 31, 2012, President Obama signed an executive order instructing the VA to “hire 1600 new mental health professionals and 800 peer-support counselors” to ensure that an individual in crisis can be helped within twenty-four hours.\textsuperscript{161} As an effort to prevent suicide, any veteran who calls the Veterans Crisis Line in crisis will be ensured that he or she will be connected with a mental healthcare professional within twenty-four hours.\textsuperscript{162} The executive order mandates a 50% expansion of the Veterans Crisis Line,

\textsuperscript{158} § 1057, 126 Stat. at 1938.
\textsuperscript{159} HARRELL & BERGLASS, CTR. FOR A NEW AM. SEC., supra note 12, at 6.
\textsuperscript{160} See § 1057, 126 Stat. at 1938.
\textsuperscript{161} Brauser, supra note 13.
as well as the expansion of the number of mental health professionals available beyond the traditional business hours.\textsuperscript{163} To better understand the underlying mechanisms of PTSD and to better the coordination between the DoD, VA, and the Health and Human Services (HHS), the executive order required the establishment of a National Research Action Plan within eight months of the execution of the order.\textsuperscript{164} Additionally, President Obama established an interagency task force, “co-chaired by the Secretaries” of the DoD, VA, and HHS,\textsuperscript{165} to formulate policies to improve diagnosis and treatment for PTSD.\textsuperscript{166} To further offer support to veterans in crisis, the DoD created a “Real Warriors” campaign and website.\textsuperscript{167} 

2. Veteran Treatment Courts

Generally, veterans who have PTSD have the tendency to exhibit behavior leading to their involvement in the criminal justice system.\textsuperscript{168} Since 2008, veterans treatment courts (VTCs)—an alternative “justice system [that] incorporates advanced ‘problem-solving’ strategies in its sentencing practices,” allowing veterans to escape a conviction by giving them a second chance—are being formed to deal with veterans’ mental health issues.\textsuperscript{169} The number of problem-solving courts has been increasing rapidly; “[a]s of 2012, there are over 3648 problem-solving courts in the United States.”\textsuperscript{170} Currently, 104 VTCs exist in the United States,\textsuperscript{171} which were modeled after the first one formed in New York.\textsuperscript{172} States, such as Alaska and California, have created their own courts just for veterans, with the purpose of providing veterans proper healthcare treatment instead of just incarcerating them.\textsuperscript{173} VTCs are created because it has been found that “there is a direct link between PTSD and the commission of crimes” due to the symptoms of PTSD leading

\begin{itemize}
\item \textsuperscript{163} Id.
\item \textsuperscript{164} See id. at 54,784–85.
\item \textsuperscript{165} Id. at 54,785.
\item \textsuperscript{166} Brauser, supra note 13.
\item \textsuperscript{167} Id.
\item \textsuperscript{168} What Is a Veterans Treatment Court?, JUST. FOR VETS, http://www.justiceforvets.org/what-is-a-veterans-treatment-court (last visited Apr. 21, 2013).
\item \textsuperscript{169} McGuire & Clark, supra note 50, at 2; Evan R. Seamone, Reclaiming the Rehabilitative Ethic in Military Justice: The Suspended Punitive Discharge as a Method to Treat Military Offenders with PTSD and TBI and Reduce Recidivism, 208 MIL. L. REV. 1, 2 (2011).
\item \textsuperscript{170} Seamone, supra note 169, at 34–35.
\item \textsuperscript{171} The History, JUST. FOR VETS, http://www.justiceforvets.org/vtc-history (last visited Apr. 21, 2013).
\item \textsuperscript{172} McGuire & Clark, supra note 50, at 2.
\item \textsuperscript{173} Marcia G. Shein, Post-Traumatic Stress Disorder in the Criminal Justice System: From Vietnam to Iraq and Afghanistan, FED. LAW., Sept. 2010, at 42, 49.
\end{itemize}
to violent or criminal behavior, and formation is motivated by the occurrence of PTSD among veterans seeking justice. Problem-solving courts, such as VTCs, are extremely beneficial for veterans, as they shift the focus from the victim’s interest to the defendant’s interest, allowing for therapeutic justice instead of retributive justice. Additionally, a VTC judge, who only hears cases involving veterans, is in a better position to exercise discretion and provide more effective relief than a normal judge who adjudicates a case involving a veteran only periodically. A VTC judge may also better understand the effect of PTSD on veterans. The creation of VTCs are likely to reduce the negative effects of PTSD, such as suicide rates, by ensuring that veterans are placed in programs where they can receive treatment for PTSD, ultimately preventing veterans from committing suicide. A treatment program through the VTC includes a bi-weekly appearance in court at a minimum during the early phases of a treatment program, required attendance at treatment sessions, and frequent testing for substance use.

B. Public Awareness Campaigns & Efforts to Reduce Stigma

Veterans are put in a very difficult situation when they return home and realize that they may need help. Veterans likely shy away from mental healthcare options due to the stigmas associated with having PTSD, often in the form of negative reactions and criticism from potential employers, and frequently exacerbated when the veteran is located in geographical areas with sparse resources. As an effort to reduce the stigma, briefings for legislative staff in Washington D.C. were hosted during mental health awareness month. The Comprehensive Soldier Fitness program was also created “to reduce PTSD . . . by promoting mental resilience.”

The Re-Engineering Systems of Primary Care Treatment in the Military (“RESPECT-Mil”), a program that screens and treats members with PTSD,

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176. Id.
177. What Is a Veterans Treatment Court?, supra note 168.
178. Id.
179. See Brauser, supra note 13; What Is a Veterans Treatment Court?, supra note 168.
180. What Is a Veterans Treatment Court?, supra note 168.
181. See Brauser, supra note 13. Veterans “living in rural communities had significantly fewer visits [to physicians] than those living in urban areas. . . .” Id.
182. Id.
183. Id.
has been instituted into approximately ninety clinics worldwide. RESPECT-Mil allows for veterans to receive treatment and be screened for mental illnesses in a primary care setting. Enabling veterans to receive such treatment in a primary care setting helps reduce stigmas by "‘[m]aking behavioral health screening as standard as a blood pressure check.’"

Furthermore, RESPECT-Mil has an automatic web-based setting that will flag patients who have not shown any improvement in eight weeks, which in turn signals the physician to change the course of treatment to one that might prove more effective.

Additionally, as an effort to end stigmatization, President Obama changed a firmly-rooted policy by announcing that condolence letters would be sent to the families of the veterans who committed suicide during service to the United States.

C. Intervention

Another service designed to assist soldiers and veterans is the National Suicide Prevention Lifeline (NSPL). The NSPL provides twenty-four hour emotional support to veterans in crisis. Additionally, chat services such as the Veterans Crisis Line connect veterans in crisis or their family members with responders who are both caring and qualified to help; aid is available via text message, online chat, or a confidential hotline. Veterans and their loved ones can receive free support, resources, referrals, assessments, information, and, if necessary, rescue services can be implemented to prevent an individual from committing suicide. Furthermore, suicide hotlines set up by the federal government have designated a special extension number for veterans.

184. Id.
186. Id.
187. See id.
190. Id.
192. See id.
Additionally, as an effort to treat suicidal ideation, the Army granted three million dollars to Michael J. Kubek, Ph.D, a research expert on thyrotropin-releasing hormone (TRH), to research the effects of a nasal spray containing TRH. Once the spray is sprayed into the nasal cavity, it is dispersed into the brain where it can control suicidal ideation.

V. OPINION

In order to actually understand and address the issue of suicide among veterans that have PTSD, cooperation across many jurisdictions and organizations is integral. The United States DoD, VA, HHS, and Congress must coordinate with one another to share data and find a way to promote uniformity in terms of healthcare administration and recording data for veterans. While President Obama is taking steps to make such unity possible, it must be done promptly.

Access to adequate mental healthcare should be a guaranteed right for veterans because of the job they are made to do. To ensure that returning veterans have access to the proper healthcare they need, proper measures must be taken to increase resources and healthcare providers.

Since many veterans will not seek specialized care for mental needs, more systems like RESPECT-Mil that “‘frontload[] the healthcare system and enable[] [primary care doctors] to identify the people who are in the greatest need’” should be implemented. This will also help alleviate issues associated with the lack of resources and healthcare providers, since more responsibility is placed on primary care physicians. Furthermore, emphasis should be placed on rendering outpatient services and behavioral therapy. Additionally, attempting to retain the veterans who are receiving treatment should be prioritized in order to learn how to improve outcomes. Preventing veterans from discontinuing treatment for PTSD can start with

195. Id.
196. HARRELL & BERGLASS, CTR. FOR A NEW AM. SEC., supra note 12, at 9.
197. Id.
199. Manzel, supra note 1.
200. HARRELL & BERGLASS, CTR. FOR A NEW AM. SEC., supra note 12, at 6.
201. Brauser, supra note 13.
202. See id.
203. See id.
204. Id.
the elimination of the negative stigma associated with PTSD. Outcomes and management of veterans can improve by obtaining “[s]pecific knowledge of the best predictors of suicidal ideation,” which will be facilitated if veterans continue to attend treatment. Moreover, suicide amongst veterans with PTSD can be reduced if more focus is placed on research on PTSD and suicide.

To better help a veteran with PTSD treat symptoms, the approach taken by mental healthcare professionals should be specifically altered for veterans with PTSD, distinct from the treatment taken for a civilian with PTSD. One of the main differences between veterans and other trauma survivors is the victimization exhibited by the individual. For example, while a rape victim might feel like they could have done more to prevent their rape, veterans often feel guilty and shameful about more rational things that are harder to justify, such as killing an innocent person. Therefore, the methods utilized to aid a civilian through victimization might not be appropriate for a veteran. Because challenging the feelings of shame and guilt a veteran feels are rightly resisted, justifying those feelings might not be the most effective way to treat a veteran. Instead, the root of the problem that the veteran is facing, such as the trigger for guilt, should be identified, and ways to make reparations for that guilt should be recommended.

VI. CONCLUSION

Unfortunately, PTSD is a real illness affecting returning veterans and is connected to an increase in suicide rates. This problem cannot be rectified without public awareness campaigns, reducing stigma for those going into the armed services and returning home with PTSD, more education and training for all levels of command in the military as well as mental healthcare professionals, and research leading to more treatment options as well as de-

205. See Harrell & Berglass, Ctr. for a New Am. Sec., supra note 12, at 5; see also Blumenthal, supra note 193.
206. Nye et al., supra note 70, at 1144.
207. See Brauser, supra note 13.
208. See Blumenthal, supra note 193.
209. See Foa & Meadows, supra note 32, at 475–76.
210. Id. at 475.
211. Id.
212. See id.
213. Id.
215. See Madison, supra note 188.
Detecting the problem earlier, Representative Grace Napolitano summed it up best: “We put these people in harm’s way . . . so I think it’s up to us in this country to at least ensure that they get all the assistance needed to bring them back to society in a workable fashion.” It is the duty of the United States Government to take care of the individuals that volunteered their lives to serve the country; failure to do so will turn young Americans away from voluntarily enlisting. If we were as quick to help veterans as we are to send them off to war, suicide rates among veterans with PTSD would not be as high.

216. See Harrell & Berglass, Ctr. for a New Am. Sec., supra note 12, at 8–9; see also Brauser, supra note 13.